1 SUPERIOR COURT OF THE STATE OF CALIFORNIA
2 FOR THE COUNTY OF LOS ANGELES
3
RICHARD BOEKIN)
4)
Plaintiff,) Case No. BC226593
5)
vs.)
6)
PHILLIP MORRIS, INCORPORATED,)
7 a corporation; INTERNATIONAL)
HOUSE OF PANCAKES,)
8 INCORPORATED, a corporation;)
DOES 1-100, inclusive,)
9)
Defendants.)
10 _____)
11
12
13 Deposition of BERNARD WEINTRAUB,
14 M.D., taken on behalf of the Plaintiff,
15 at 11755 Wilshire Boulevard, Suite 1170,
16 Los Angeles, California, commencing at
17 11:35 a.m., on Friday, March 16, 2001,
18 reported by Vivian C. Dernburg, CSR
19 No. 11339, a Certified Shorthand Reporter
20 in and for the State of California
21 pursuant to Notice.
22
23
24
Reported by: Vivian C. Dernburg, CSR No. 11339
25 Job No.: 0016-VCD

1 APPEARANCES:
2 For the Plaintiff:
3 LAW OFFICES OF MICHAEL H. PIUZE
By: MICHAEL H. PIUZE, ESQ.
4 11755 Wilshire Boulevard
Suite 1170
5 Los Angeles, California 90049
(323) 655-5353
6
7 For the Defendant Phillip Morris:
8 ARNOLD & PORTER
By: CHERYL A. WILLIAMS, ESQ.
9 777 South Figueroa Street
44th Floor
10 Los Angeles, California 90017-5844
(213) 243-4036
11
- and -
12
SHOOK, HARDY & BACON, LLP
13 By: CHRIS JOHNSON, ESQ.
One Market
14 Steuart Tower, Ninth Floor
San Francisco, California 94105-1310
15 (415) 904-6300
16
17
18
19

20
21
22
23
24
25
3
1 I N D E X
2 WITNESS: BERNARD WEINTRAUB, M.D.
3
Examination by: Page
4 Mr. Piuze 5
5
6 E X H I B I T S
7 1 - Curriculum vitae of Bernard Weintraub, 6
M.D.; 4 pages
8
2 - Handwritten list of articles read by 54
9 Bernard Weintraub, M.D. for the
Boekin case; 4 pages
10
3 - Photocopy of staging criteria for 88
11 lung cancer; 1 page
12 4 - Handwritten record of time spent 92
on Boekin case by Bernard Weintraub,
13 M.D.; 1 page
14
15
INSTRUCTION NOT TO ANSWER
16
PAGE LINE
17
13 24
18 15 15
15 22
19
20
21 MARKED QUESTIONS
22 (None)
23
24
INFORMATION REQUESTED
25
(None)
4
1 Los Angeles, California
2 Friday, March 16, 2001
3 11:35 a.m.
4
5 BERNARD WEINTRAUB, M.D.,
6 called as a witness by and on behalf of the
7 Plaintiff was duly sworn by the reporter and
8 testified as follows:
9
10 EXAMINATION
11 BY MR. PIUZE:
12 Q Good morning.
13 A Good morning.
14 Q What's your name?
15 A Bernard Weintraub.
16 Q Your occupation?
17 A I'm a physician.
18 Q What kind?

19 A I'm a pulmonologist.
20 Q Do you have a C.V. with you?
21 A Yes.
22 Q Can I see it.
23 Up to date?
24 A Yes.
25 MR. PIUZE: This is No. 1 here.
5
1 (The document referred to was
2 marked by the C.S.R. as Plaintiff's
3 Exhibit 1 for identification and was
4 attached to and made part of this
5 deposition.)
6 BY MR. PIUZE:
7 Q Who are the two people sitting on
8 the side of the table with you?
9 A Cindy and Chris.
10 Q Cindy and what?
11 A Cindy Williams and Chris Johnson.
12 Q Okay. How do you know Cindy?
13 A I know her through my interactions
14 regarding this case.
15 Q Well, that's what I want to know,
16 about your interactions. So how do you know
17 her? How did you get introduced to her?
18 A Can you be more specific?
19 Q No, that's pretty specific. How
20 did you get introduced to her? Did Joe Smith
21 say this is Cindy or did Mitsy Dobson say this
22 is Cindy or how did you get introduced to her?
23 A I was introduced to her by Chris.
24 Q Okay. When?
25 A Approximately two months ago, I
6
1 believe.
2 Q Who does Cindy work for?
3 A I'm not sure which firm she
4 represents.
5 Q Who does Chris work for?
6 A He worked for Shook Hardy & Bacon.
7 Q Who does Shook Hardy & Bacon work
8 for?
9 MS. WILLIAMS: Objection. Calls
10 for speculation.
11 THE WITNESS: I'm sure they work
12 for a lot of employers.
13 BY MR. PIUZE:
14 Q Well in this case, who do they
15 work for?
16 A They work for one or more of the
17 tobacco owe companies.
18 Q Which one?
19 A I'm not sure certain.
20 Q Do you know the name of this case?
21 A Could you be more specific.
22 Q This lawsuit -- do you know the
23 name of the lawsuit?
24 A The name of the lawsuit or the
25 name of the party involved.
7
1 Q Well, there are two parties. It's
2 A vs. B. Smith vs. Joan, someone vs. someone.
3 Do you know the name of this case?

4 A It's Boekin vs. -- Lorillard.
5 Q Okay. How do you know Chris?
6 A I know Chris because he works with
7 Shook, Hardy & Bacon, and has asked me to
8 consult on this case.
9 Q How were you introduced to Chris?
10 MS. WILLIAMS: Objection. Lacks
11 foundation.
12 THE WITNESS: I was introduced to
13 him at a meeting some number of months ago.
14 BY MR. PIUZE:
15 Q Okay. Who introduced you to him?
16 A Another attorney who was present
17 at the time.
18 Q And that attorney had a name?
19 A Correct, which I don't recall at
20 the moment.
21 Q A woman?
22 A No.
23 Q Okay. What firm was the other
24 attorney from?
25 A Shook Hardy & Bacon .
8
1 Q Okay. Curtis, right?
2 MS. WILLIAMS: Objection. Lacks
3 foundation.
4 THE WITNESS: That would be
5 correct.
6 BY MR. PIUZE:
7 Q What?
8 A That is correct.
9 Q Curtis Lemay?
10 A I believe that's correct.
11 Q Okay. Two for two.
12 How did you get in touch with
13 Curtis.
14 MS. WILLIAMS: Objection. Lacks
15 foundation.
16 THE WITNESS: I'm sorry, repeat
17 the question, please.
18 BY MR. PIUZE:
19 Q How did you get in touch with
20 Curtis? How did you and Curtis hook up?
21 A I received a phone call at some
22 point.
23 Q From?
24 A From possibly Curtis or possibly
25 another party, and I can't recall at this
9
1 point.
2 Q Before this lawsuit involving my
3 client, Richard Boekin, had you ever had any
4 dealings with Shook, Hardy & Bacon before?
5 A Yes.
6 Q When?
7 A Last fall.
8 Q What?
9 A A case I was consulting on.
10 Q Tobacco case?
11 A Correct.
12 Q What was your role?
13 MS. WILLIAMS: Objection. Calls
14 for information protected by the attorney work

15 product.
16 MR. PIUZE: I don't think so.
17 MS. WILLIAMS: To the extent he
18 was not disclosed as an expert in that case.
19 BY MR. PIUZE:
20 Q Have you ever given a deposition
21 in a tobacco case before?
22 A No.
23 Q Have you ever given a deposition
24 before?
25 A Yes.
10
1 Q In what kind of case?
2 A In malpractice cases.
3 Q How many?
4 A Approximately five.
5 Q Do you remember for what side?
6 A Plaintiff and defense, depending
7 on the case.
8 Q Who's hired you from the plaintiff
9 side?
10 A Specifically, which attorneys?
11 Q Yeah.
12 A I don't remember the names of the
13 attorneys at this point.
14 Q The firms?
15 A Again, I don't recall the names of
16 the firms at this point.
17 Q Who's hired you from the defense
18 side?
19 A Kurtz, Feldman and Rubin.
20 Q Only?
21 A There was another case, and I
22 can't remember for that case who the attorney
23 was.
24 Q How many times have you consulted
25 in medical malpractice cases -- I'm not talking
11
1 about giving depos now, I'm talking about
2 consulting?
3 A Approximately six.
4 Q And in five out of those six
5 cases, you've given a deposition?
6 A Correct.
7 Q How many tobacco cases have you
8 consulted in or on?
9 A Including this one?
10 Q Yes.
11 A Two.
12 Q Okay. Shook, Hardy was your
13 sponsor in both?
14 MS. WILLIAMS: Objection. Vague
15 and ambiguous as to "sponsor."
16 BY MR. PIUZE:
17 Q Shook, Hardy hired you on both?
18 A I've consulted for them both
19 cases.
20 Q What was your role in the other
21 case?
22 A I acted as a consultant to review
23 records.
24 Q What was the bottom line?
25 MS. WILLIAMS: Objection. Calls

12
1 for information protected by the attorney work
2 product.
3 (Interruption in proceedings.)
4 (A discussion was held off the
5 record.)
6 BY MR. PIUZE:
7 Q Go ahead.
8 A I'm sorry, what was the question?
9 Q Well, I'm not sure because she was
10 objecting, she was talking, she was typing, and
11 you were looking at me, and I was
12 discombobulated. But we'll find out.
13 MR. PIUZE: Yeah, that same
14 objection, if the reporter wants to read that
15 back to you.
16 (The record was read by the
17 reporter as follows: "
18 THE WITNESS: Could you be more
19 specific.
20 BY MR. PIUZE:
21 Q Yes. Did the cancer get caused by
22 tobacco, is that it?
23 MS. WILLIAMS: Objection.
24 Instruct the witness not to answer.
25 MR. PIUZE: You can't instruct not
13
1 to answer for a non-client. First of all, you
2 don't have a privilege --
3 MS. WILLIAMS: I'm protecting the
4 privilege of my clients --
5 MR. PIUZE: Who are your clients?
6 MS. WILLIAMS: Phillip Morris.
7 BY MR. PIUZE:
8 Q Was Phillip Morris involved in the
9 other case?
10 A I don't recall at this point.
11 MR. PIUZE: So you can't do that.
12 That's B.S. You're pulling it out of the sky,
13 plus your client isn't Phillip Morris. He's
14 already told you the name of the case is
15 Lorillard.
16 MS. WILLIAMS: You know who my
17 client is.
18 MR. PIUZE: He told you it's
19 Lorillard.
20 MS. WILLIAMS: You know who my
21 client is. Don't be cute.
22 MR. PIUZE: I can't help it if I'm
23 cute. You don't have a right to do that. I
24 have an exact right to cross-examine this
25 witness for bias and prejudice, and if you
14
1 don't know the name -- there are 40,000 people
2 who are going to die. How are they ever going
3 to figure out which one they're consulting out.
4 MS. WILLIAMS: You don't have a
5 right to figure that out.
6 MR. PIUZE: I know we're close to
7 trial, and I know you're saying, "He's not
8 going to make a motion." But you're wrong.
9 You can't instruct him not to answer. He's not
10 your client. I can instruct him to do

anything.
Q Now, I want you to answer my question. What was the bottom line of the case whether or not tobacco caused lung cancer?
MS. WILLIAMS: My instruction stands.
BY MR. PIUZE:
Q I'm telling you that she doesn't have any right to be instructing you to do anything, and I want you to answer my question, Doctor, please.
MS. WILLIAMS: Same instruction.
BY MR. PIUZE:
Q Are you going to answer my question?

15

A I've been instructed not to answer the question.
Q By whom?
A Cindy.
Q So what? So she's instructing you not to, and I'm instructing you to. Why do you go for her? I'd be interested to explore this under oath. Why are you listening to her, cause she's paying you?
A No, because it feels appropriate to.
Q It does? Well, I'll guess I'll have to get around it. Tell you what pulmonology feels like, cause I don't know anything about it. So I wouldn't be so presumptuous to tell you about it?
MS. WILLIAMS: Objection. Argumentative.
BY MR. PIUZE:
Q How does it feel appropriate, Doctor?
A I'm not sure what you're asking.
Q Well, you told me it feels appropriate to do what she tells you to do. I want to know why is that?

16

MS. WILLIAMS: Objection. Argumentative.
BY MR. PIUZE:
Q Why?
A Because you appear to be somewhat hostile.
Q Somewhat hostile. That's what they say about the Indians.
MS. WILLIAMS: Maybe they're right.
BY MR. PIUZE:
Q Is that your answer?
A Yes.
Q Okay. You're probably right. But you're not right not to answer the question. Who introduced you to the Shook, Hardy firm originally?
MS. WILLIAMS: Objection. Lacks foundation.
THE WITNESS: I received a phone

call at some point in time and as I believe I mentioned it may have been Curtis Lemay who called me but I am not certain about that at this point.

Q Now, I'm back earlier than that, Curtis and Shook, Hardy. I want to know how you got contacted from Shook, Hardy?
A That's correct.
Q Do you know who Mitsy Dobson is?
A Yes.
Q Do you know who she is?
A She's an attorney.
Q Who works for Bonne Bridges?
A Yes.
Q Who does med. mal.?
A That's correct.
Q Now that I put her name out here, does that refresh your recollection that she might have been the conduit between you and Shook, Hardy?
MS. WILLIAMS: Objection. Lacks foundation, assumes facts not in evidence.
THE WITNESS: I'm not certain.
BY MR. PIUZE:
Q Anyway, I'd like to hear about your dealings with the lawyers in this case, the Boekin case. Curtis was the first person who called you and told you what?
A My recollection of the

conversation was that he asked or whoever called me asked if I would be interested in doing consulting work for their law firm.
Q Okay. Did you ask what kind of consulting work?
A Yes.
Q What did he tell you?
A He told me that they are a firm who represents some of the tobacco companies in tobacco litigation.
Q Sure. So what kinds of consulting work did he tell you about.
A Generally, my recollection was it was a brief conversation. He asked me if I was interested in reviewing cases.
Q For what?
A For defense in tobacco companies.
Q What was your issue going to be? What were you looking for?
MS. WILLIAMS: Objection. Assumes facts not in evidence.
THE WITNESS: There was no specific issue addressed in that conversation as far as I can recall.
BY MR. PIUZE:

Q Okay. So what did you think you were going to be looking at the records for?
A I assumed I would be looking at the records for evidence of tobacco-related disease or lack of evidence.
Q Okay. Did you feel you're

7 qualified to do that?
8 A Yes.
9 Q What makes you qualified to do
10 that?
11 A I'm a physician by training. I'm
12 a pulmonary specialist.
13 Q Okay.
14 A I think those are reasonable
15 qualifications.
16 Q Well, aside from litigation, here,
17 when in the real world do you ever get called
18 upon, if ever, in your day-to-day practice, to
19 determine whether or not a disease process
20 tobacco related?
21 A Could you rephrase that question
22 for me.
23 Q I could, but it's a pretty clear
24 question.
25 When you're not consulting with
20
1 tobacco companies, when in the real world in
2 your everyday practice do you ever get called
3 to render an opinion whether a disease process
4 is tobacco-related?
5 A Do you mean formally called upon?
6 Q Well, let's starts with formally
7 called upon.
8 A Infrequently.
9 Q Well, what does that mean? Ever?
10 Never?
11 A Sometimes.
12 Q When?
13 A Sometimes patients ask.
14 Q What?
15 A They may ask whether smoking
16 caused their illness.
17 Q You mean, whether smoking caused
18 their lung cancer?
19 A Among others.
20 MS. WILLIAMS: Objection. Lacks
21 foundation.
22 BY MR. PIUZE:
23 Q What others?
24 A What others?
25 Q You said "among others." Your
21
1 phrase. "What others," emphysema?
2 A Correct.
3 Q What others?
4 A Chronic bronchitis.
5 Q What else?
6 A Heart disease.
7 Q That's far afield for a
8 pulmonologist, isn't it?
9 A No.
10 Q Okay. That's four. Anything
11 else?
12 A Peripheral vascular disease.
13 Q 5. I hope you remember these
14 because I'm not writing them down, and I'm
15 going to ask you about these.
16 Anything else?
17 A Other cancers.

Q That's 6. All of the above.
Let's go through them.
How often has a patient of yours
with lung cancer said, "Doctor, is this a
tobacco-related illness?"
A Occasionally.
Q About how often? I'd like your
best estimate.

A That would be difficult for me to
quantify in any of those situations.
Q Okay. I'd like your best
estimate.
A I'm not sure I can give you an
estimate.
Q Would it fit in a bread box?
A I'm not sure what you're asking
me.
Q Is it less than 100?
A I don't know what the number is.
Q I'm asking for your best estimate.
I'm entitled to that best estimate. It may be
important to your testimony.
Has this happened less than 100
times?
A I would be guessing.
Q Has it happened more than 10
times?
A Yes.
Q More than 50 times?
A Yes.
Q More than 75 times?
A Probably.
Q More than 100 times?

A Probably.
Q More than 150 times?
A We're getting into the range of
more guesswork.
Q Between 150 and 100, is that
comfortable?
A I don't know specifically.
Q Less than 200?
A I think I'm giving you my best
answer.
Q Well, you haven't, yet you've told
me this probably happened more than 100 times.
Now, I want to put an upper parameter on it.
Was it less than 200?
MS. WILLIAMS: Objection. Asked
and answered. He's told you he's guessing at
this point.
BY MR. PIUZE:
Q Go ahead.
A As a guess, I'd say an upper
parameter of 3 to 400.
Q I don't want you to guess, though
I'm entitled to your best estimate here. I'm
not playing games. I've got other things to
do. I'm not trying to waste your time. I'm

entitled to your best estimate, and I don't
want you to guess.

A But I would be guessing at this point. That's the problem that I have.
Q So the best estimate you can give is it's something more than 100?
A I think that is my best answer.
Q And you can't put an upper limit, correct?
A Yes.
Q So what has your answer been?
MS. WILLIAMS: Objection. Vague and ambiguous.
THE WITNESS: I'm sorry?
BY MR. PIUZE:
Q The question was, "I've got lung cancer, was it tobacco related?" What was your answer?
MS. WILLIAMS: Objection. Vague and ambiguous.
THE WITNESS: I would say, in general, the answer was, yes.
BY MR. PIUZE:
Q Well, have you ever said no --
A Yes.

Q -- to a patient?
A Yes.
Q Can you picture that patient?
A More than one patient.
Q Okay. So you can picture who it is, right?
A Specifically the name?
Q No, just picture, a face. I'm not going to ask you a name. Can you picture a face?
A Yes.
Q Okay. How many faces?
A Somewhere between 5 and 10.
Q So what I'm hearing is at an absolute minimum, if 100 is the right number of people that ask that question, 90 to 95 percent of the people, you say to, "Yes, your lung cancer is tobacco related"?
A That would be correct.
Q And if it turned out that the upper limit would be 3 or 400, 98 percent would be, "Yes, your cancer is tobacco related," correct?
MS. WILLIAMS: Objection. Vague and ambiguous.

MR. PIUZE: No, just good math.
THE WITNESS: That is correct.
MR. PIUZE: That was doing it on the fly.
Q Of it's 300 and you get 295 out of 300, we're talking about 99 percent. And if it's 400 and you get 395 out of 400, we're talking about more than 99 percent. So, okay. Now, what about the people with emphysema, how many people have said to you, "Doctor, I've got emphysema. Is my emphysema tobacco related?"
A I'm sorry. The question is how

many patients have asked?
Q Yeah.
A I don't know the exact number.
Some have; some haven't.
Q I'm sure. Does this have a
feeling of familiarity to it? Why don't you
give me your best estimate, range as to how
many people have asked you this, please.
A As a percentage, I would guess
probably 30 percent may have asked that
question.
Q Okay. Well, that means nothing to

me because, of course, I don't know how many
people you have treated with emphysema. How
many people have asked?
A I'm not sure.
Q Your best estimate, please.
A My best guess would be probably
somewhere between 150 and 200.
Q Okay. Now, you heard me say at
least three or four times try not to give
guesses. I'd like your best estimate. Tell us
your best estimate. You heard all of that
before?
A Yes.
Q Okay. Why do you choose to use
the word "guess," then?
A Because I don't have recall of the
numbers of patients that I've seen or the
percentages who have asked those questions.
Q Is that your best estimate?
A That is the best I can think of at
this point.
Q Okay. Let's go back to the lung
cancer. The 5 to 10 people to whom the answer
was no, I'd like to know why the answer was no.
A In those situations, because they

were either non-smokers or they were people who
had had smoking history either in the remote
past or at a very low level.
Q Let's eliminate those 5 to
10 -- excuse me.
Of those 5 to 10 people, let's
eliminate the ones who never smoked. Let's
eliminate the ones who had a remote smoking
history. Let's remove the ones who smoked very
little. Are we left with 0?
A Left with 0 in terms of?
Q "No, patient, your lung cancer is
not tobacco related."
A I think that would be correct.
MR. PIUZE: Do I have some shoes
here?
Q So, believe it or not, all of that
came off of an answer of yours, and your answer
was "formally." Do you remember that answer
where you said formally?
A Yes.
Q Okay. Let's go to "informally."
If formally, f-o-r-m-a-l-l-y -- if
formally -- I mean -- I hate this. I'll be

25 doing this in trial. They show me my card.
29
1 Nobody knows this and perhaps it's boring.
2 If "formally" is when a patient of
3 yours flat out asks, what is "informally"?
4 MS. WILLIAMS: Objection. Lacks
5 foundation.
6 THE WITNESS: "Informally" would
7 be to me a situation in which perhaps another
8 physician asked or someone who was interested.
9 BY MR. PIUZE:
10 Q Under what circumstances would
11 another physician ask?
12 A Generally, a physician who was
13 involved in taking care of the patient.
14 Q Would ask whether or not the
15 patient's lung condition was related to
16 tobacco?
17 A Rarely.
18 Q I mean, why would a treating
19 physician care about that, seriously?
20 A I think, in general, physicians
21 are interested in what their patients are doing
22 and what's made them sick.
23 Q Is that your best answer?
24 A Yes.
25 Q So what kind of a physician would
30
1 be asking you, a pulmonologist, what -- whether
2 or not your mutual patient's lung cancer was
3 tobacco-related?
4 A Any physician who was curious.
5 Q I know. But I'm trying to figure
6 out how it works. In the real world, would it
7 be who -- it wouldn't be a pathologist, would
8 it? It wouldn't be a radiologist. Who would
9 it be?
10 A It would be anybody who's
11 interested.
12 Q And who has that been?
13 A Generally physicians who were
14 taking care of the patients.
15 Q I know. What kind of physicians,
16 seeing that you're the lung specialist?
17 A Well, generally, it would include
18 either internists or family practitioners most
19 commonly.
20 Q Okay. Anyone else that you can
21 recall?
22 A Perhaps, rarely, another
23 subspecialist on the case.
24 Q Such as?
25 A Any subspecialist.
31
1 Q Okay. When you were talking about
2 the physicians generally, you used the word
3 "rarely" or a synonym, didn't you?
4 A Correct.
5 Q Now, when we're talking about a
6 subspecialist, we're talking about rarely of
7 rarely, a double negative, rarely to the second
8 degree.
9 MS. WILLIAMS: Objection. Vague

and ambiguous.
BY MR. PIUZE:
Q Do you understand that?
A No.
Q The physicians are rarely
subspecialists, correct?
A Yes.
Q Of the physicians who ask, the
physicians who rarely ask are subspecialists?
A Well, subspecialists are generally
less involved than general physicians.
Q Can you think of any case where
you actually have a memory of another physician
asking you in regards to a mutual patient, "Is
Patient X's lung cancer related to tobacco?"
Can you actually remember a time when that
32
happened?
MS. WILLIAMS: Objection. Lacks
foundation.
THE WITNESS: I don't remember a
specific time.
BY MR. PIUZE:
Q Okay. Back to "informally."
Besides the situation where perhaps another
doctor treating the same patient might have
asked you that question, does "informally"
encompass anything else?
MS. WILLIAMS: Objection. Vague
and ambiguous.
THE WITNESS: Not that I can think
of.
BY MR. PIUZE:
Q Okay. If No. 2 was emphysema,
what was No. 3?
A I'd have to ask for the next one
on the list.
Q This is like one of these tests
where you go to some college where they say,
"Remember these things because I'm going to ask
you again."
Do you remember No. 4?
33
A Not in order.
Q Okay. Where's your office?
A In Santa Monica.
Q Where do you have privileges,
Santa Monica Hospital, St. Johns?
A Correct.
Q Anyplace else?
A Daniel Freeman, Marina; UCLA,
Westwood and Vencor, Los Angeles.
Q What is that?
A Vencor is a chronic respiratory
care center.
Q Where?
A In Culver City.
Q Where in Culver City?
A On Slauson.
Q Who goes there, people with what
kind of problems?
A Patients go there with many
different kinds of problems, medical problems,

21 respiratory problems, generally fairly sick
22 patients who require longer term care than the
23 average hospital patient.
24 Q And how long a term does the
25 average hospital patient have, just generally
34
1 speaking?
2 A I'm not sure.
3 Q How long does the Vencor
4 patient -- we're talking about somebody that
5 goes down there for months at a time?
6 A It's usually weeks to months at
7 that facility.
8 Q Are those people on machines down
9 there?
10 A Many of them are.
11 Q Why don't you tell me some of the
12 types of problems that you treat problems for
13 down at Vencor.
14 V-e-n-c-o-r?
15 A Correct.
16 Q Tell me what types of problems you
17 treat people down there for, please.
18 A We treat patients there for
19 respiratory failure, pneumonia bacteremia,
20 sepsis syndrome, other types of infections,
21 patients with wounds that require chronic
22 long-term care.
23 Q Why do you put your malpractice
24 carrier on your C.V.?
25 A I think it's parts of the relevant
35
1 information.
2 Q Why?
3 A I just try to be as inclusive as
4 possible.
5 Q As what?
6 A As inclusive as possible.
7 Q Do you know Judith Brill?
8 MS. WILLIAMS: Objection. Vague
9 and ambiguous.
10 THE WITNESS: No.
11 BY MR. PIUZE:
12 Q Carlos Maggi, M-a-g-g-i?
13 MS. WILLIAMS: Same objection.
14 THE WITNESS: No.
15 BY MR. PIUZE:
16 Q Is there a board certification in
17 pulmonary diseases?
18 A Yes.
19 Q Is that what it's called,
20 pulmonary diseases?
21 A Correct.
22 Q And you're board certified in
23 critical care?
24 A Correct.
25 Q Critical care doctors are often,
36
1 in fact, strictly pulmonologists, correct?
2 A That's correct.
3 Q Have you ever practiced as a
4 critical care doctor?
5 A Critical care is a significant

6 part of my practice.
7 Q What do you do critical care wise?
8 A Can you be more specific.
9 Q Yeah. I'm just trying to picture
10 what setting you're being a critical care
11 doctor in and what you're doing as a critical
12 care doctor. I think I got a pretty good idea,
13 but I want to make sure we're on the same
14 wavelength?
15 A Generally, in critical care, we
16 take care of patients who are generally in the
17 intensive care unit or are going into the
18 intensive care unit, and they generally have
19 life-threatening diseases of one type or
20 another. And we try to manage their problems.
21 Q Frequently on respirators?
22 A Correct.
23 Q You're in charge of people on
24 respirators, aren't you? You're in charge of
25 that care, aren't you?
37
1 A Correct.
2 Q Do you do critical care at all of
3 the hospitals you've listed on your C.V.?
4 A Yes.
5 Q How do you get privileges at UCLA,
6 Westwood?
7 A The process is the same as any
8 other hospital, to my understanding.
9 Q If you were not -- let's see. It
10 says that for -- says, meaning on Exhibit 1,
11 your C.V., that for 10 years, you were an
12 assistant clinical professor at UCLA School of
13 Medicine, correct?
14 A Correct.
15 Q What if you hadn't been? Could
16 you have privileges at UCLA, Westwood if you
17 hadn't been a clinical professor there?
18 A I don't know the answer to that.
19 Q To put it differently, can some
20 doctor -- you know, otherwise reputable with no
21 problems and no past affiliation with the med.
22 school, get privileges at UCLA Med. Center?
23 MS. WILLIAMS: Objection. Calls
24 for speculation.
25 THE WITNESS: I don't know.
38
1 BY MR. PIUZE:
2 Q Do you know Dr. Cryer, C-r-y-e-r?
3 A No.
4 Q Who is the head of critical care
5 over at UCLA?
6 A I believe it's still Paul Bellamy,
7 although he might have stepped down recently.
8 Q When's the last time you had a
9 critical care patient over at UCLA?
10 A Last week.
11 Q What were you doing for that
12 patient?
13 A Can you be more specific?
14 Q Yeah, re-managing their airway?
15 A The patient was on a ventilator.
16 Q How did you get involved with that

particular patient over there? Was it your preexisting patient who went to UCLA?
A That's correct.
Q Okay. And do you ever get cold-called from UCLA when they see we have someone here, Mr. X and Mrs. X, and we need a critical care specialist? Can you come over?
A Cold-called by whom?
Q The hospital.

39

A Well, the hospital, as far as I know, doesn't call consultants. Individual doctors would be the ones who called the consultants.
Q Okay. There are critical care doctors on staff at UCLA, right?
A Yes.
Q Name a couple.
A Paul Bellamy goes there. Streiter goes there, Mike Levine, Bob Shpinner, they all do critical care.
Q What percentage of your time do you do critical care medicine?
A Total?
Q Yeah.
A I would say 20 to 25 percent as a guess.
Q You mean as an estimate, don't you?
A Maybe you could explain to me the difference between a guess and an estimate for this purpose.
Q Guesses aren't allowed in court. Estimates are.
A I see.

40

MS. WILLIAMS: Objection. Vague and ambiguous.
THE WITNESS: That would be an estimate.
BY MR. PIUZE:
Q Okay. What takes up the remaining 75 -- excuse me. I apologize. Withdraw that. How long has critical care accounted for 25 percent of your practice?
A I would say for at least 10 years, probably longer.
Q And prior to that, was it more or less of your practice, less, right?
MS. WILLIAMS: Objection. Lacks foundation.
THE WITNESS: I think it's stayed more or less the same to the best of my recollection.
BY MR. PIUZE:
Q When were the first boards in critical care?
A I believe that was in 1989.
Q Okay. So you were in there pretty quickly after the specialty had its own individual book?

41

A Correct.

Q What makes up the 0.75 percent of your medical practice?
A Some of it is taking care of non-critical pulmonary patients. Some of it is in involvement with doing hospital internal medicine, not always pulmonary. And then I have the office part of my practice, which is almost 100 percent pulmonary.
Q What kinds of non-pulmonary internal medicine do you practice in hospitals?
A We admit patients with other medical problems and take care of them.
Q Such as?
A Congestive heart failure, GI bleeding, patients with other cardiac issues.
Q So for GI bleeding, you don't calm a gastroenterologist to do that?
A Generally, I do.
Q And with congestive heart failure, you don't call in a heart specialist?
A Generally, it would depend on the severity of the problem.
Q You said "we" on several of your answers. Who is the "we"?

42

A The "we" includes my office associates.
Q Other doctors?
A Correct.
Q How many doctors are in your office?
A Three, including me.
Q The other two are pulmonologists also?
A Yes.
Q Critical care specialists also?
A Yes.
Q Is there a name for the group?
A No.
Q Are you partners?
A No.
Q Do you just share expenses as far as managing the practice is concerned?
A Correct.
Q Okay. And cover for each other?
A Correct.
Q How long have you been at 2021?
A I believe it's been approximately eight-and-a-half years.
Q Do you do any pediatric pulmonary medicine?

43

A No.
Q Do you do any pediatric critical care medicine?
A No.
Q Back to Curtis, how many times have you met Curtis, if at all?
A I've met him two times that I can recall.
Q Where?
A In my office.
Q Has it ever been just the two of

you in a meeting?
A No.
Q Who's been present?
A At the first meeting, Chris was there. At the second meeting, Chris was there, and, I believe, Cindy was there.
Q Cindy, meaning the lady next to you?
A Correct.
Q I've seen a blonde, tall, thin blonde from Kansas City who sometimes is part of the group. Do you recall her?
A Yes.

44

Q What's her name?
A Pat.
Q Pat what?
A Mary Pat, actually, I believe. Marry Pat Riordan.
Q That's very good. What does she do?
A She's an R.N.
Q What did she say?
A I'm sorry?
Q What did she ever say to you?
A Could you be more specific?
Q No. That's pretty specific.
A I think I need a more specific question.
Q What did she say to you?
A I think I need a little more direction to your question.
Q Why?
A Cause I'm not sure what you're asking.
Q Did you ever hear her say anything?
A Yes.
Q Other than a pleasantry, like,

45

"Hi," "by"?
A Yes.
Q "Nice day," nice seeing you," have you ever heard her say anything?
A Yes.
Q What?
A She's been at several of the meetings.
Q Okay. What's the answer to my question? What has she said to you?
A I can't remember any specific information or discussion with her.
Q What about Chris, what has Chris ever said to you?
A He's said a number of things to me.
Q Tell me. I don't want pleasantries. Obviously, we can forget "Hi," "by," "I'm Chris. I'm from San Francisco. She's from Kansas City. She's from Ontario." Did you know she's from Ontario?
A No.
Q Do you know how far Ontario is

24 from here?
25 Listen to this answer. Listen to
46
1 this answer. How far is Ontario?
2 A Which Ontario?
3 Q Good answer. What has Chris said
4 to you?
5 A We've had discussions about the
6 two cases that I was reviewing.
7 Q I'm not interested in your
8 discussions in the Boekin case. I'm only
9 interested in discussions about the other case
10 with Chris.
11 MS. WILLIAMS: Are you asking for
12 the substance of those conversations?
13 Objection. Calls for information
14 protected by the attorney work product
15 privilege.
16 BY MR. PIUZE:
17 Q What information did Chris tell
18 you about the Boekin case?
19 A He didn't tell me anything
20 specific. He asked me to review the case.
21 Q Well, he obviously said more than
22 "just review the case," cause I know his M.O.
23 cause all the other doctors have told me what
24 he's said.
25 MS. WILLIAMS: Objection. Assumes
47
1 facts not in evidence.
2 THE WITNESS: I could try to
3 answer the question if you could be a little
4 more specific.
5 BY MR. PIUZE:
6 Q What did he say about the Boekin
7 case?
8 A He asked me to review the records
9 and asked me what I thought about the case, and
10 we discussed that on several occasions.
11 Q Was your answer always the same?
12 MS. WILLIAMS: Objection. Lacks
13 foundation.
14 THE WITNESS: Answer to what?
15 BY MR. PIUZE:
16 Q The question. You just
17 said -- didn't you just say he discussed what
18 did you think about the case on several
19 occasions?
20 A Yes.
21 Q Was your answer always the same?
22 A I believe my answer was
23 consistent.
24 Q Was it always the same?
25 MS. WILLIAMS: Objection. Lacks
48
1 foundation.
2 THE WITNESS: Yes, to the best of
3 my recollection.
4 BY MR. PIUZE:
5 Q Okay. And what about your lawyer
6 here who's objecting here for you and
7 instructing you? Has she ever said anything to
8 you other than pleasantries, obviously?

9 A Yes.
10 Q What?
11 A Again, she was involved in the
12 discussion of the case to a lesser extent.
13 Q Okay. What did she say?
14 A I don't really recall specific
15 comments.
16 Q All right. What did you tell her?
17 A About?
18 Q The case.
19 A I told her that my opinion
20 depended upon the pathology of the case, and
21 that if the diagnosis in this case is an
22 adenocarcinoma, that I felt that that was
23 smoking-related.
24 Q That would be non-controversial,
25 wouldn't it?
49
1 A I think so.
2 Q Other specialists from the local
3 area retained by Phillip Morris -- it's not
4 Lorillard, it's Phillip Morris -- on this case
5 have testified about relationships or
6 correlations with statistics where both smoking
7 and adenocarcinoma are involved. Have you been
8 told about what any of the other consultants
9 for Phillip Morris have said?
10 A No.
11 Q Do you have in mind some kinds of
12 statistics that link tobacco and
13 adenocarcinoma?
14 A I have general impressions of the
15 statistics.
16 Q Tell me, please.
17 A In the majority of cases of
18 adenocarcinoma, smoking is the cause and
19 effect.
20 Q Majority covers a lot of
21 territory, specifically between 51 and 100.
22 Can you be more specific?
23 A It's much higher than 51 percent,
24 and it's less than 100 percent, and my best
25 estimate would be that it's somewhere between
50
1 75 and 90 percent.
2 Q One of the consultants, I
3 believe -- I hope I'm not misstating this --
4 for Phillip Morris made some kind of a
5 statement like, "Smokers are blank times" -- I
6 don't want to tell you the number of times
7 because I don't want to close in on your
8 thought process -- "are blank times more likely
9 to get adenocarcinoma than non-smokers." Do
10 you have a number that you feel comfortable in
11 filling in the blank?
12 A No, I don't have a number.
13 Q If I suggested a number that over
14 20 times, that smokers are 20 times more likely
15 to get adenocarcinoma than non-smokers to you,
16 does that sound like a reasonable number to
17 you?
18 A That does not sound unreasonable.
19 Q You would not disagree?

A I wouldn't disagree with it. I wouldn't have a basis for stating or rendering whether that actual number is correct.
Q I'm with you.
Could you find out?
MS. WILLIAMS: Objection. Vague

51

and ambiguous.
THE WITNESS: I could look into the literature and try to get a best estimate of what that number would be.
BY MR. PIUZE:
Q Has Chris given you a reading assignment?
MS. WILLIAMS: Objection. Vague and ambiguous as to "reading assignment."
THE WITNESS: No.
BY MR. PIUZE:
Q Has Chris given you a list of publications that he thought you might be interested in reading?
A No.
MS. WILLIAMS: Objection. Vague and ambiguous.
BY MR. PIUZE:
Q Has Chris actually given you publications he thought you might be interested in reading?
A Yes.
Q Are they on the table?
A Some of them are on the table -- well, let me rephrase that.

52

Everything I've looked at for this particular case is on the table except for the MEDLINE search that I did.
Q Is the stuff that's on the table a mixed bag of Chris's articles and your articles, or is it all Chris's articles?
A It's a mixed bag.
Q What percentage of it is Chris's?
A Most.
Q And as we already discussed, that covers a lot of territory, like 51 to 100. Can you be more specific?
A I would guess probably 80 to 90 percent.
Q That would be your estimate?
A Correct.
MR. PIUZE: Let's just go off the record for a second.
(A discussion was held off the record.)
BY MR. PIUZE:
Q What did you choose to review that's on the table?
A Everything.
Q You read everything that's on the

53

table?
A Correct.
Q Which of those articles on the table did you choose as opposed to Chris

choosing?
MS. WILLIAMS: Objection. Vague and ambiguous as to "choose."
THE WITNESS: I don't remember at this point.
BY MR. PIUZE:
Q Okay. How can we identify this stuff on the record so it never goes away? Do you have a list of -- a title list that's on a page so we can just attach it to the record?
A Yes, I do.
Q Can I have it, please.
Was your handwriting like this before you were a doctor?
A It was best better, slightly.
MR. PIUZE: The list is Exhibit 2.
(The document referred to was marked by the C.S.R. as Plaintiff's Exhibit 2 for identification and was attached to and made part of this deposition.)

54

BY MR. PIUZE:
Q Now, just so I can be clear, is this list only the documents that you've given me in the box?
A That's correct.
Q So whatever you got off of MEDLINE is not on Exhibit 2?
A Correct.
Q What did you get off of MEDLINE?
A I reviewed on MEDLINE approximately 250 titles and tried to sort through those on the computer and read what appeared to be appropriate for this topic.
Q How many did you get?
A Only about three or four.
Q Did you print them out?
A No, I didn't.
Q What do you do as an independent medical examiner for the State of California?
A I occasionally, very occasionally see workers' compensation patients in the office for an evaluation.
Q That's it?
A Yes.
Q What are the MEDLINE articles that

55

you chose to read, do you know?
A No. I don't remember the titles at this point.
Q Author?
A No.
Q So anyway, you were telling me if it was adenocarcinoma, there's probably a relationship between the lung cancer and tobacco, correct?
MS. WILLIAMS: Objection. Misstates his testimony.
THE WITNESS: Repeat the question for me.
(The record was read by the reporter as follows: "So anyway, you were

telling me if it was adenocarcinoma, there's probably a relationship between the lung cancer and tobacco, correct?)
THE WITNESS: I think in cases of adenocarcinoma, I think there is probably a relationship between adenocarcinoma and the tobacco use.
BY MR. PIUZE:
Q Just so I'm not confusing you necessarily here, I'm back 10 minutes in our

56

conversation. You were discussing Mr. Boekin's case with one or more of these lawyers. I asked you what you told them, and you started out by saying it was dependent upon what the path slides said. And if the path slides were read to be adenocarcinoma, then there's a relationship between lung cancer and the tobacco someplace between 75 and 90 percent. Is that a pretty good characterization?
A Correct.
Q What was the other choice?
A The other choice was based upon the review of this case and if this would be a bronchoalveolar carcinoma, rather than a adenocarcinoma.
Q What if it was BAC?
MS. WILLIAMS: Objection vague and ambiguous.
BY MR. PIUZE:
Q Just so that we're on the same wavelength.
A Fine. So can you repeat that last question.
BY MR. PIUZE:
Q "What if it was BAC" -- I think

57

that was the question -- then what's your opinion?
A Well, if this were a bronchoalveolar carcinoma, my opinion about that is the relationship between that and smoking is not consistent, and it would be much less likely to be related to the tumor.
Q Your opinion regarding adenocarcinoma being a 75 to 90 percent probable relationship to smoking and BAC being a much less clear, jury's out kind of situation in relationship to smoking, are opinions that are widely held by specialists of your specialty, pulmonology, correct?
A That's my understanding.
Q Okay. In other words, you're not on the periphery for either of these issues, you're, rather, in the mainstream for them?
A I believe so.
Q Okay. So let's talk about BAC a little bit. What out there now and days in current literature is there that you think links BAC with smoking, and then I'm going to -- I wouldn't ask you now, but I'll subsequently ask you what out there tends not

58

to link BAC with smoking?
So let's go for the first one.
First, what out in the literature now, if anything, tends to link BAC with smoking?
A Well, there are some reports I've seen which suggest that there may be some incidence related to BAC and smoking, that it may depend in part on how recent or how remote the smoking was. But it seems to be less related, as far as I can tell, to the amount of smoking done by the patient.
Q Okay. The more recent, the more likely the like?
A The more recent for?
Q Smoking.
A Smoking. The more likely the link. There is some information that would suggest that, and I've also seen some information that seems to suggest that even with people who smoked, but stopped, there may be some relationship.
Q Okay. We're on a probability kind of question now. Is the general feeling that if there is a relationship between BAC and smoking, it's more likely to exist where the

59

smoking is recent?
A I didn't get that out of my review. I'm not sure I got an answer to that question one way or the other.
Q Fine. And you've already told me that there doesn't seem to be any thought that the amount of smoking is a variant, right?
A Right.
Q Well, all that sort of boils down to so far is some people think that smoking and BAC are related, right?
A Correct.
Q Okay. Let's go to -- and is that your whole answer?
The question was what out there in the current literature links BAC and tobacco smoke, and is the answer simply that some authors do?
A Some authors and some studies.
Q And can you quantify the link in these studies?
A I don't think I can quantify it based on what I've seen.
Q Strong, weak, moderate, big, little, numbers, anything like that?

60

A I wouldn't be able to come up with numbers. I think the quantification in terms of general description would be weak or a little bit more than weak was my impression in reading it.
Q Okay. What out there in the literature now and days tends to say that there is no link between BAC and tobacco smoke?
A What I've seen in terms of describing a lack or relative lack of relationship is data regarding either

genetic -- possible genetic links, possible viral etiology, such as oncogenes, o-n-c-o-g-e-n-e-s, potential toxic exposures. Sugarcane workers would be one example.
Q Give me others -- let me interrupt you.
What other kinds of exposures?
A Motor workers.
Q What is a motor worker?
A Someone who works on engines. Oil petroleum products, I believe, is one potential exposure.
Q Are motor workers sometimes known in the real world as mechanics?

61

A Right.
Q Okay. What else?
A Scars, scar carcinomas.
Q I'm sorry. I apologize. We were on toxic, subset of toxic. You've told me the kinds of stuff you get out in the sugarcane fields. You told me the kind of stuff you get from running motors. Are there any other kinds of toxic stuff linked to BAC?
A There are others, and unfortunately, I can't recall all of them at the moment.
Q What's an oncogene?
A An oncogene, to my understanding, is a gene or particle that's transmitted potentially by a virus, and the virus, then, is able to enter a cell of whatever type and essentially change the DNA of the cell that it enters.
Q Okay. So off of toxics now, you were saying genetics, scars, oncogenes, toxics. Anything else?
A Those would be the ones I can think of right now.
Q Okay. And those all fall into the

62

category of the other potential causes for BAC?
A Correct.
Q So are they ranked?
A Are they ranked in terms of?
Q Probability.
A I have not seen a ranking like that.
Q So what if I could find a person and the person never worked around motors and never worked in sugarcane field, and somehow we know the person doesn't have a scar but the person smokes, what do you do with that?
MS. WILLIAMS: Objection. Vague and ambiguous.
THE WITNESS: What do we do with that in terms of what?
BY MR. PIUZE:
Q Figuring out if the tobacco and the BAC are related.
A Well, the question -- the other difficult question that I think would be difficult to answer in a case like that would

23 be whether the patient could have had another
24 genetic predisposition at that point or whether
25 there was the presence of viral oncogenes.
63
1 Q Well, no one could ever prove that
2 there were tracks of a viral oncogene?
3 A I'm not an expert in this stuff.
4 Q It's like an ice ball. It does
5 its damage and leaves no tracks, right?
6 A I don't know.
7 Q What about genetics? What if
8 someone is genetically disposed to lung cancer,
9 what does that mean?
10 A It means to me that they're more
11 likely to get a lung cancer if they're
12 genetically predisposed.
13 Q More likely, but something has to
14 occur, does it not, to start the cancer off?
15 MS. WILLIAMS: Objection. Lacks
16 foundation.
17 BY MR. PIUZE:
18 Q Or does nothing have to occur, an
19 oncogene virus, a sugarcane, a motor or
20 something?
21 A I don't know of the answer to
22 that.
23 Q First of all, is it established
24 that there is genetic predisposition to lung
25 cancer?
64
1 A Based on what I've reviewed, there
2 appears to be in some patients.
3 Q And what would we be looking for?
4 MS. WILLIAMS: Objection. Vague
5 and ambiguous.
6 THE WITNESS: In the history, we'd
7 be looking for evidence in the family,
8 possibly, of a similar malignancy.
9 BY MR. PIUZE:
10 Q Okay.
11 A That would be one piece of
12 information one would want to get.
13 Q What other information?
14 A If it were feasible to do genetic
15 studies, then that would certainly be relevant.
16 I don't know if that's the case at this point.
17 Q What about Mr. Boekin's history
18 for genetics for lung cancer?
19 MS. WILLIAMS: Objection. Vague
20 and ambiguous.
21 BY MR. PIUZE:
22 Q Do you know anything about that?
23 A I'd be happy to read his history
24 and tell you. Again, I don't recall whether or
25 not there was a family history or not.
65
1 Q Okay. Whether or not he has a
2 family of lung cancer or not plays no role in
3 your opinions that you've expressed thus far,
4 correct?
5 A Repeat the question for me.
6 (The record was read by the
7 reporter as follows: "Okay. Whether or

not he has a family of lung cancer or not plays no role in your opinions that you've expressed thus far, correct?")
BY MR. PIUZE:
Q Family history of lung cancer.
A Can you just rephrase that for me.
Q Sure. If you don't know if there is any kind of family history of lung cancer in Mr. Boekin's family, then, therefore, whether there is or isn't, does not play a role in the opinions that you've expressed thus far obviously.
A Correct.
Q Okay. What if someone is genetically predisposed to lung cancer, that fact wouldn't rule out something else like sugarcane, oncogenes, working around motors, smoking from being a causative factor of the

66

lung cancer, would it?
A I would agree with that.
Q I'm sorry?
A I would agree with that.
Q Okay. Have you told me all that you can say right now about the current literature in regard to BAC not caused by tobacco smoke?
A I think I've given a fair synopsis for that issue.
Q Fine. What percentage of lung cancers are BACs?
A In general, what I've read is in the range of approximately 3 percent, give or take some.
Q What percent of lung cancers are adenocarcinomas?
A My reading suggests that adenocarcinomas at this point are the most common or have become the most common lung cancer. So that would be probably over 50 percent.
Q I'd caution you that the fact that they're most common doesn't necessarily put them in the majority. You may know that

67

independently, but one doesn't necessarily follow the other.
My having stated that to you, do you want to say probably over 50 percent?
A I've seen numbers that I can recall right now in the range of 40 percent to 45 percent. So they would still perhaps be the most frequent tumor, although I agree, it doesn't have to be over 50 percent.
Q I've heard over the last few days from Phillip Morris consultants that have given depositions in this case that the number of BAC diagnoses seem to be going up with time.
MS. WILLIAMS: Object to the use of "Phillip Morris consultants" as vague and ambiguous.
BY MR. PIUZE:
Q Is that the impression you get

from the reading?
A What I've seen suggests that BACs have gone up in frequency as well as the adenocarcinomas in general.
Q And do you have a feeling for whether or not that is simply due to newer, better or different diagnostic slash reporting
68
techniques as opposed to the fact that there are literally, truly more such cases than there used to be?
A I'm not sure.
Q Okay. Have you ever seen BAC in your clinical practice?
A Yes.
Q How?
A How, meaning --
Q How do you see it on a path report?
A I've seen several patients who came in for a diagnostic evaluation who ended up having BAC.
Q Who decided that they ended up having BAC?
A The pathologist.
Q That's the pathologist's job, right?
A Correct.
Q Have you ever overruled or counter ruled a pathologist on that call?
A No.
Q Describe a BAC to me.
MS. WILLIAMS: Objection. Vague
69
and ambiguous.
THE WITNESS: Can you be more specific?
BY MR. PIUZE:
Q What does it look like?
MS. WILLIAMS: Objection. Vague and ambiguous.
THE WITNESS: I need a little more specific guidance for the question.
BY MR. PIUZE:
Q Sure. I can guide you. There's a jury that you're going to be in front of or that may be -- I'm going to read this very question to, and a lot of them have probably never looked through a microscope to see what cancer looks like. So for us -- and neither have I. And so for us folks who have never done it -- you know, maybe I can say what does a dog and a cat look like and you can describe a dog and you can describe a cat. And then we would know the difference, or what does a dog look like or what does a fish look like. And after you've described it to us, if we've never seen one of those, we'd know the difference. And I want you to
70
describe what a BAC looks like under that microscope versus what an adenocarcinoma looks like under a microscope.

4 A I see. I'm not a pathologist, so
5 I don't have expertise of a pathologist. But
6 from my understanding under the microscope of
7 BAC is that, number one, the tumor cells are
8 lined in the alveoli. They grow along the
9 walls of the alveoli. They can grow up through
10 the airways, and they tend to do -- frequently,
11 they tend to be not invasive. In other words,
12 they don't tend to invade the walls of the
13 alveoli or septi. They grow in that fashion.
14 Q Okay. Do you want to make any
15 comments on size, whether they travel in packs,
16 how they're grouped together, anything like
17 that?
18 MS. WILLIAMS: Objection. Vague
19 and ambiguous.
20 THE WITNESS: Under the
21 microscope?
22 BY MR. PIUZE:
23 Q Yeah, sure.
24 A I'm not sure I have any other
25 comments on that issue.
71
1 Q Describe an adenocarcinoma for
2 this jury that may be listening to this
3 question.
4 MS. WILLIAMS: Objection. Vague
5 and ambiguous.
6 THE WITNESS: Again, as a
7 non-pathologist, my description of an
8 adenocarcinoma would be under the microscope
9 that there are cells which tend to grow in
10 small formations. They tend to be invasive for
11 the most part. There may or may not be scar
12 formation either within the tumor or around the
13 tumor.
14 Q End of answer?
15 A Yes.
16 Q Okay. So if BACs are currently
17 having grown in popularity up to 3 percent of
18 lung cancers -- that's right so far, isn't it?
19 A That's my best estimate, is about
20 3 percent.
21 Q And if adenocarcinomas are
22 someplace in the vicinity of 50 percent, the
23 most frequent type, that's right, isn't it?
24 A I think that's approximately
25 correct.
72
1 Q What's left?
2 A What's left in terms of?
3 Q Sounds like there's about 47
4 percent left?
5 A Oh, other kinds of cancers?
6 Q Yeah, lung cancer.
7 A Squamouscell, large cell and small
8 cell would be the main categories.
9 Q Can you put an approximate
10 percentage or frequency of total lung cancers
11 on those three categories, please.
12 A I believe that squamouscell is the
13 next most frequent, which to my recollection is
14 in the range of approximately 30 percent or so

and then small cell and then large cell.
Q Besides the lawyers for the tobacco company, have you talked to anyone else about this case?
A No.
Q What else do you have on the table with you?
A I have a copy of the notes I made regarding the time I've spent on the case.
Q How much?
A I have not added it up yet.

Q Are the numbers there?
A Yes.
Q Go ahead and take 30 seconds and add it up, please.
A So far, it looks like approximately 28 hours.
Q "So far," meaning right up until the minute today?
A Up until before today.
Q When did you meet with the lawyers today?
A Before this deposition.
Q I know. I figured that part out all by myself. Starting when?
A 10:00 o'clock.
Q Okay. How much do you get paid by the hour to be doing this consulting work please?
A $300.
Q How much do you get paid by the hour to be doing the deposition?
A $500.
Q What percentage of your professional income -- I don't want to know about your stocks, bonds, and I wouldn't want

to put you through the pain of telling me. What percent of your professional income is derived from legal activity?
A It's very low. I'm trying to figure out what the number would be.
Q Is it smaller than the percentage of BAC to all lung cancers?
A Yes.
Q That is very small then, right?
A Correct.
Q Who was the pathologist who stated what type of lung cancer Mr. Boekin had?
MS. WILLIAMS: Objection. Vague and ambiguous.
THE WITNESS: Does your question refer to the medical record?
BY MR. PIUZE:
Q No. It's actually open-ended. Do you know of more than one pathologist who has stated what type of lung cancer Mr. Boekin has?
A No.
Q So I guess if you don't know more than one, who is that one?
A I believe it was Dr. Geller, to my recollection.

75
1 Q Do you know Dr. Geller?
2 A Not personally.
3 Q By reputation?
4 A Yes.
5 Q What's his reputation?
6 A He has a reputation as a competent
7 pathologist.
8 Q Is he the head over at Cedars?
9 A I believe that's correct.
10 Q How big of a hospital is Cedars?
11 A It's a very large hospital.
12 Q In this town, this major world
13 city of Los Angeles, is it the largest or one
14 of the three largest? Do you know where it
15 ranks?
16 A It's one of the largest. I don't
17 know if it's the absolute largest.
18 Q Do you have any idea how many
19 pathologists are on staff over at Cedars?
20 A No.
21 Q Did you read his pathology report?
22 A Yes.
23 Q What did he say?
24 A He said in the final diagnosis
25 that this was a papillary adenocarcinoma, and
76
1 there was a frozen section which had a
2 diagnosis of a bronchoalveolar carcinoma.
3 Q From your position, do you have
4 any idea if one of those two should outrank the
5 other?
6 A Well, generally, a frozen section
7 would be less reliable --
8 Q Why?
9 A -- than a final report.
10 Q Why?
11 A As a non-pathologist, my
12 understanding is that the fixation is done
13 differently -- fixation of the tissue, and
14 because it's usually done at the time of
15 surgery, there's less time taken to review the
16 specimen and the slides.
17 Q But if that specimen -- is that
18 specimen typically preserved?
19 A I'm not sure what the question is.
20 Q Well, so they don't take a lot of
21 time doing it, but can't you get the specimen
22 at some later date and take an hour to look at
23 it?
24 A From a frozen section?
25 Q Yeah.
77
1 A I believe a frozen section is to
2 be done right on the spot. That's my
3 understanding.
4 Q And then what happens then? It's
5 like the ice ball, it melts?
6 A I don't know.
7 Q I'm not asking to be facetious.
8 Let me ask you something, does the
9 frozen section get destroyed, discarded? What
10 happens to it?

A I don't know.
Q With respect to there was not as much time to look at the frozen section, explain other reasons you think it might not be as accurate to look at the frozen section.
MS. WILLIAMS: Objection. Vague and ambiguous.
BY MR. PIUZE:
Q One of the things you said is fixation. Explain that.
A When a section is taken and it goes to pathology, usually the specimen is placed in a fixative, and a frozen section is not placed in a fixative.
Q How does the fixative make it

variable? How does it make it more or less accurate?
A I don't know the answer to that.
Q I appreciate you are not a pathologist cause you've said that many times, and you've prefaced your answer with that. And I appreciate that you will bow to and not question the opinion of a pathologist cause you've stated that in your previous testimony. And understanding that, what do you think about the possibility that a lung cancer tumor can have a mixed set of sub-cancers such as, maybe, a little papillary adenocarcinoma and maybe a little BAC strain in the adenocarcinoma. From your standpoint as a pulmonary specialist, do you think that's possible?
A Yes.
Q And why do you think that's possible?
A Because I've seen cases like that, and I've read about cases like that.
Q What if it happens like that and now you've got a tumor that's adenocarcinoma which you now say in your own mind, "Uh-huh, 75

to 90 percent probably linked to tobacco," but it's also got some features to BAC, and you say but much less of a probability comes up there. Then the question comes up, "Does this tumor relate to tobacco smoke smoking?" Where does your thinking go from there?
A I would have to depend on the pathologists to give me a reading to make that kind of assessment. I don't think I'm capable of doing that.
Q So let's talk about Mr. Boekin, then. Let's assume that I never pushed you to say, "Hey, Doctor, remember you told me that a frozen section is less accurate than the final diagnosis," and instead I ask you to assume that in Mr. Boekin's case, there is some papillary adenocarcinoma and there is also some BAC in this tumor. You wouldn't be able to give me any kind of an opinion as to whether or not his tumor was related to smoking, or would you?

22 A I would have a very difficult time
23 doing that.
24 Q Okay. This is your chance. If
25 you want to have a difficult time, go ahead and
80
1 have it right in front of me so I'll know about
2 it at trial. If you're going to defer it
3 totally, let me know that?
4 A I would defer to the pathologists.
5 Q Okay. What other opinions do you
6 have in this case, please.
7 A The other issue or opinion that I
8 have is relating to his presentation
9 clinically.
10 Q Please, tell me.
11 A I think his clinical presentation
12 is consistent with either of the two potential
13 types of cancer that he appears to have based
14 on the medical record.
15 Q When you say "either of the two,"
16 what are the two candidates?
17 A Either a papillary adenocarcinoma
18 or a bronchoalveolar carcinoma based on the
19 pathology reports.
20 Q What are all of the features of
21 his presentation that are consistent with BAC,
22 please?
23 A Those features were that he had a
24 lesion, which was less than 3 centimeters, and,
25 we believe, it was about 1 1/2 to 2 centimeters
81
1 in size. It was a fairly peripheral lesion,
2 and the CT report commented that there was a
3 lobar bronchus which appeared to go towards the
4 tumor. But there was no comment on any
5 compression of the bronchus by tumor.
6 Q Is that the end of your answer?
7 A Yes.
8 Q Your on the spot now. I'd like to
9 hear that.
10 (The record was read by the
11 reporter as follows: "Those features were
12 that he had a lesion, which was less than
13 3 centimeters, and, we believe, it was
14 about 1 1/2 to 2 centimeters in size. It
15 was a fairly peripheral lesion, and the CT
16 report commented that there was a lobar
17 bronchus which appeared to go towards the
18 tumor. But there was no comment on any
19 compression of the bronchus by tumor.")
20 BY MR. PIUZE:
21 Q That's pretty good, wasn't it?
22 A I liked it.
23 Q I mean, she got it word for word,
24 right?
25 A Correct.
82
1 Q What does compression have to do
2 with it?
3 A There have been some descriptions
4 in the literature regarding some of the
5 radiology findings regarding bronchoalveolar
6 carcinoma commenting that there's something

7 called an "open airway sign," which is
8 something that there's an airway that goes
9 towards or to the lesion but is not compressed
10 or altered in any significant way.
11 Q Now, have you told me all of the
12 factors which tend towards a diagnosis of BAC
13 in Mr. Boekin?
14 A Well, I think this presentation is
15 consistent with either one.
16 Q I recall that. I'm just -- let me
17 say my question more artfully.
18 Have you told me all of the
19 factors that make his presentation consistent
20 with BAC?
21 A Yes, I think so.
22 Q Tell me the factors that make his
23 presentation consistent with adenocarcinoma or
24 papillary adenocarcinoma, if you'd rather?
25 A I think they're really the same
83
1 factors. It's peripheral, which
2 adenocarcinomas tend to be. The size is
3 consistent with that type of a lesion, and it
4 would be, in my opinion, a fairly typical
5 presentation for an adenocarcinoma.
6 Q If that's true -- and I'm not
7 questioning you on that; I'm not challenging
8 you on that. If that's true and if we put the
9 path slide aside, the odds of it being
10 adenocarcinoma versus BAC are approximately 45
11 to 3, correct?
12 MS. WILLIAMS: Objection.
13 Misstates his testimony.
14 THE WITNESS: Well, if you take
15 the clinical presence in terms of the chest
16 X-ray and the CAT scan and you try to make an
17 estimate as to the percentage of it being BAC
18 versus an adenocarcinoma, it would be much more
19 likely to be an adenocarcinoma.
20 Q Right. But I'm putting numbers on
21 it, 45 adeno, 3 BAC based on your own
22 testimony.
23 A Well, those are the percentages
24 based on -- as far as I know, those tumors
25 relative to the entire lung cancer spectrum.
84
1 Q Right.
2 A So in that context, I think that
3 would be correct.
4 Q Well, do you have another context?
5 A Not that I'm thinking of.
6 Q Okay. Well, what about -- so
7 that's the opinion you wanted to give me
8 regarding his presentation, correct?
9 A Correct.
10 Q Is that the extent of your opinion
11 regarding his presentation?
12 A Yes.
13 Q Can we determine whether or not
14 this lung cancer is BAC versus papillary
15 adenocarcinoma by looking at his films?
16 A Not in my opinion.
17 Q We have to look at the slides in

order to make the final determination?
A Correct.
Q Who's Dr. Hammer? Did you ever
hear of Dr. Hammer?
A I don't know that name.
Q Okay. He's got a museum about
four blocks down that way.
A Arm & Hammer?

85

Q Well, that's Dr. Hammer, isn't it?
A That's one Dr. Hammer.
MR. PIUZE: Do you have your
expert witness designation by any chance?
MS. WILLIAMS: I don't think I
brought it.
MR. PIUZE: Let me take a minute
and go get it. I'm almost done.
MR. JOHNSON: I might have it.
MS. WILLIAMS: Can we talk for a
sec? Don't get scared.
(Recess taken.)
MR. PIUZE: Where were we, the
disclosure?
MR. JOHNSON: I don't have your
disclosure. I have the notice, if you want the
names.
BY MR. PIUZE:
Q Do you have any opinions regarding
the treatment of Mr. Boekin?
A As to what treatment issues?
Q Any opinions whatsoever. I mean,
I don't want you to just recite the history to
me. From what I remember from the disclosure
statements, all the expert witnesses who were

86

consultants on this case had similar
qualifications.
"Diagnosis."
We talked about all your opinions
on diagnosis, right?
A Right.
Q Treatment.
Do you have any opinions regarding
his treatment?
A No.
Q "Etiology" on the cancer of this
patient.
Have you told me all of the
opinions on the etiology?
A Yes.
Q "Prognosis."
It's a fatal disease, correct?
A Based on my review of his records
that I've seen so far, I think it will prove to
be fatal.
Q Do you have any opinion yourself
about how long he's going to live?
A No. I don't know that.
Q What else do you have on the
table, please.

87

A I have a copy of the staging
criteria for lung cancer.

MR. PIUZE: Let's make that Exhibit No. 3.
(The document referred to was marked by the C.S.R. as Plaintiff's Exhibit 3 for identification and was attached to and made part of this deposition.)
BY MR. PIUZE:
Q What stage was his lung cancer at presentation?
A His pathologic staging was a 3-A to my recollection.
Q Why do you answer it in terms of pathological staging as opposed to just saying staging?
A Cause there's also clinical staging which occurs when the patient is initially seen before the patient had a surgery or an actual condition.
Q What was the clinical staging?
A My recollection of the clinical staging was that it was a Stage 2. If I remember correctly, it was a Stage 2.

88

Q What else do you have?
A I have a copy of my fee schedule.
Q Okay. You can have that. I'll give it back.
What else?
A A few notes that I made on reviewing the records.
Q Could you just read those notes, please.
A "80 pack years." "10 slash 20," "PET" --
That's P-E-T.
Q What's 10 slash 20?
A The date.
Q Okay.
A "PET positive." "Mediastinoscopy. "Right peritracheal nodes negative." "10/28/99 surgery" -- I'm having trouble reading my own writing.
Q I don't blame you.
A Underneath that it says, "2AT1N1MO."
Q What does that mean?
A That refers to the staging that was done at that time, "12/14/99, Sarna,"

89

S-a-r-n-a. "First visits, 3-A, 12 slash 00, brain lesions dash MRI."
Q Do you know Sarna?
A No. Her personally?
Q I apologize for interrupting. Do you know any of the plaintiff's treating doctors?
A I know Dr. Heifetz.
Q What specialty is Dr. Heifetz?
A He's an oncologist.
Q Do you know him personally?
A I have known him personally in the past.

Q Is there a pulmonologist in Mr. Boekin's history?
A Yes.
Q Who?
A Bob Wolf.
Q When?
A Bob saw him, I believe, after his surgery.
Q Where?
A At Cedars.
Q Why?
A Because of some postop

90

bronchiospasm to my recollection.
Q You obviously know Dr. Wolf.
A I do know him.
Q Personally?
A Yes.
Q What, if anything, did he say about Mr. Boekin?
A He felt that the patient had destructive airway disease and needed respiratory treatments and postop mobilization.
Q Motil --
A Mobilization.
Q Meaning, just that, getting up and moving around?
A Correct.
Q Did he treat the cancer at all?
A Not to my recollection.
Q Have you read all of the notes on that one page?
A Yes.
Q And I'm going to give that page back to you.
The last page that's up on the table, what's that?
A This is the page of my time

91

sheets, essentially the time that I've spent on this case.
Q Right. Let me make that Exhibit 4, please.
(The document referred to was marked by the C.S.R. as Plaintiff's Exhibit 4 for identification and was attached to and made part of this deposition.)
BY MR. PIUZE:
Q Have you told me all of the opinions that you intend to give at the time of the trial in this case?
A Yes.
MR. PIUZE: I'm done.
Did you get a stipulation from the other evening?
Do you want to use the stipulation from the other evening? It's the one you insisted on 15 days.
MS. WILLIAMS: Yes. That would be fine.
(The stipulation from the deposition of Peter J. Julien, M.D., was

25 incorporated as follows:
92
1 "MR. PIUZE: Anyway, here's
2 the stipulation. You can go.
3 "The court reporter can be
4 relieved of her duty to maintain
5 the original under the Code of
6 Civil Procedure.
7 "She will send the original
8 of this deposition to whom,
9 Ms. Williams?
10 "MS. WILLIAMS: To our
11 offices.
12 "MR. PIUZE: To Arnold &
13 Porter. And if there are any
14 changes, additions deletions or
15 corrections to the transcript,
16 Ms. Williams will notify me within
17 two weeks of her receipt. If not,
18 I can use a -- my copy as if it's
19 a signed original.
20 "MS. WILLIAMS: So
21 stipulated.
22 "THE WITNESS: I have a
23 right to review that and make any
24 corrections?
25 "MS. WILLIAMS: Yes. 15
93
1 days from the time that I get it
2 to you.
3 "THE WITNESS: Okay.
4 "MR. PIUZE: Two weeks from
5 your receipt -- that's what you
6 just agreed to -- which is less
7 than 15 days.
8 "MS. WILLIAMS: I think we
9 should do 15 days since that's
10 been the standard so far.
11 "MR. PIUZE: Excuse me?
12 "MS. WILLIAMS: 15 days has
13 been the standard. That's what we
14 just said this morning.
15 "MR. PIUZE: Okay.")
16 MR. PIUZE: So we're done.
17 (Whereupon, at 1:23 p.m., the
18 deposition of Bernard Weintraub, M.D., was
19 concluded.)
20 //
21 //
22
23
24
25
94
1
2
3
4
5
6
7
8
9 I, BERNARD WEINTRAUB, M.D., do

10 hereby declare under penalty of perjury that I
11 have read the foregoing transcript; that I have
12 made any such corrections as appear noted, in
13 ink, initialed by me, or attached hereto; that my
14 testimony as contained herein, as corrected, is
15 true and correct.
16
17 EXECUTED this _____ day
18 of _____, 2001, at
19 _____, _____.
(City) (State)
20
21
22 _____
BERNARD WEINTRAUB, M.D.
23
24
25
95
1 STATE OF CALIFORNIA)
: ss.
2 COUNTY OF LOS ANGELES)
3
4 I, the undersigned, a Certified
5 Shorthand Reporter of the State of California, do
6 hereby certify:
7 That the foregoing proceedings were
8 taken before me at the time and place herein set
9 forth; that any witnesses in the foregoing
10 proceedings, prior to testifying, were placed
11 under oath; that a verbatim record of the
12 proceedings was made by me using machine
13 shorthand which was thereafter transcribed under
14 my direction; further, that the foregoing is an
15 accurate transcription thereof.
16 I further certify that I am neither
17 financially interested in the action nor a
18 relative or employee of any attorney of any of
19 the parties.
20 IN WITNESS WHEREOF, I have this date
21 subscribed my name.
22
Dated: March 19, 2001
23
24 _____
VIVIAN C. DERNBURG
25 CSR No. 11339